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PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAMS (PRRTP)

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides new policy, procedures, and detailed manual reporting requirements for the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) bed level of care.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) established the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) bed level of care in 1995. This distinct level of in-patient mental health care is appropriate for veterans with addictive disorders and serious mental illnesses who require additional structure and supervision to address multiple and severe psychosocial deficits, including homelessness. It recognizes the need for psychiatric treatment and symptom reduction of mental and addictive disorders, while also providing psychosocial rehabilitation, which focuses on a patient's strengths, and provides opportunities to improve functional status. This rehabilitative approach recognizes that persons with mental illness and addictive disorders can achieve their goals for healthy and productive lives. PRRTPs are designed to provide comprehensive treatment and rehabilitative services that will improve quality of life and diminish reliance upon more resource intensive forms of treatment.

b. The rapid development of the PRRTP level of care, prior to fully automated systems to support it, has necessitated a number of computer system "work-arounds" and manual reporting requirements.

c. PRRTP Program definitions are:

(1) **PRRTP.** A Psychosocial Residential Rehabilitation Treatment Program developed for a general psychiatric patient population not otherwise noted in these definitions.

(2) **PRRP.** A Post-traumatic Stress Disorder (PTSD) Residential Rehabilitation Program.

(3) **SARRTP.** A Substance Abuse Residential Rehabilitation Treatment Program.

(4) **HCMC CWT/TR.** A Homeless Chronically Mentally Ill Compensated Work Therapy (CWT) Transitional Residence (TR).

(5) **SA CWT/TR.** A Substance Abuse CWT TR.

(6) **PTSD CWT/TR.** A PTSD CWT TR Program.

(7) **General CWT/TR.** A CWT-based PRRTP not targeted exclusively for any particular mental health population.

NOTE: All types of CWT/TR programs must be operated in accordance with VHA Directive 2001-011, *Compensated Work Therapy Transitional Residences Program*, dated March 8, 2001.

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d. **Location.** PRRTPs may be established either on VA medical center grounds, or in community-based facilities owned, leased, or otherwise acquired by VA. Regardless of the location of PR RTP beds, they must be designated as official VA beds in accordance with VA Bed Control Policy and reported on the Gains and Losses (G&L) statement of the associated VA health care system or medical center.

e. **Staffing.** PRRTPs may be minimally staffed, since, by their residential nature, they are designed to maximize peer support and self-care, as compared to a traditional hospital bed. However, the safety and welfare of both PR RTP staff and veterans must be a primary consideration. Additionally, each PR RTP should have a multidisciplinary treatment team to ensure comprehensive assessment and delivery of services to address multi-faceted rehabilitative needs. In addition, twenty-four hour, seven day per week, on-site supervision of PRRTPs is required. The type of staffing provided will be determined by the clinical needs of the veterans served by the PR RTP and by standards applied by external accrediting bodies. In addition, professional PR RTP staff must be on call by radio, telephone or beeper at all times.

h. **Clinical Approaches.** PRRTPs may provide the full services of a 24-hour per day treatment program within the PR RTP residential program itself, or veterans in PRRTPs may participate in an intensive regimen of outpatient services, (such as outpatient substance abuse, PTSD, day treatment, vocational rehabilitation) which are then augmented by the PR RTP residential component of care. In all cases, the residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. Treatment intensity, environmental structures, milieu, and type of supervision vary based on population served and should be relevant to the diversity of the population, i.e., age, ethnicity, culture, etc. Continuity of care will be ensured by a knowledgeable treatment team utilizing a care management approach. Treatment and rehabilitation goals generally addressed in PRRTPs include, but are not limited to:

- (1) Substance abuse counseling and relapse-prevention.
- (2) Medication management.
- (3) Social, recreational and independent living skills.
- (4) Work or vocational rehabilitation therapy.
- (5) Family education and counseling.
- (6) Housing assistance.

3. POLICY: It is VHA policy to establish a residential level of bed care, distinct from medium and high-intensity in-patient psychiatry beds which provide a 24-hour therapeutic setting for veterans with multiple and severe psychosocial deficits to identify and address goals of health maintenance and improved quality of life, in addition to specific treatment of mental illnesses

and addictive disorders. **NOTE:** *Patients in residential rehabilitation programs must be medically stable, capable of self-preservation in the case of a disaster, are usually responsible for self-medication, and often prepare their own meals. PR RTP residential settings utilize a milieu of peer and professional support, with a strong emphasis on increasing personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living.*

4. ACTION

a. The following veterans should be screened for their need of psychosocial residential treatment services:

(1) Veterans requiring 24-hour supervised care who do not meet Interqual criteria for Acute Psychiatry admission,

(2) Veterans receiving outpatient mental health services who lack a stable lifestyle or living arrangement that is conducive to recovery. The following examples are provided to illustrate where residential rehabilitation services are clinically indicated:

- (a) Substance use disorder patients with likelihood of relapse while in outpatient treatment.
- (b) Patients diagnosed with PTSD who are likely to be upset by treatment interventions.
- (c) Homeless veterans with multiple and complex Axis IV psychosocial deficits.
- (d) Potentially unstable psychotic patients.

b. **Beds.** VA PR RTP beds may be established in addition to, or in lieu of Extended Care beds and/or Domiciliary beds, contractual, or community partnership arrangements for residential treatment. PR RTP beds are not to be used solely to address transportation difficulties associated with accessing outpatient treatment, or as a means of temporary lodging.

c. **Approval Authority.** Approval authority for establishment, change or closure of PR RTP beds will be in accordance with VHA Directive 1000.1, VHA Directive 99-030, Authority for Mental Health Program Changes, dated June 30, 1999.

d. **Accreditation.** All PR RTPs must be accredited under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for Behavioral Health Care (24-hour settings). PR RP, SAR RTP and (general) PR RTPs who wish to be recognized for state-of-the-art rehabilitative approaches may also choose to be accredited under the Residential Treatment Standards of Commission for Accreditation of Rehabilitation Facilities (CARF). All types of CWT TRs must be accredited under CARF Standards for Community Housing.

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e. **Residential Costs.** Veterans in PR RTP programs may not be charged residential costs, such as lease expenses, utilities, maintenance, meals, etc., except within CWT TR programs.

NOTE: See VHA Directive 2001-011, for detailed policy and procedures regarding CWT TR legal authorities and programming.

f. **Eligibility.** PR RTP is considered “hospital care” for purposes of eligibility determinations; therefore, eligibility rules for hospital care would apply for PR RTP admissions.

g. **Monitoring.** The Northeast Program Evaluation Center (NEPEC) located at the VA Connecticut Healthcare System at West Haven, monitors initial implementation of PR RTPs by conducting an annual survey of facilities reporting PR RTP workload. Outcomes monitoring, to include measures of efficiency, effectiveness and veteran satisfaction are to be developed at each local program as part of quality improvement initiatives, and are to be periodically reviewed for opportunities to improve veteran outcomes and PR RTP performance. ***NOTE:*** *Nationally, the PR RTP component of the mental health care continuum will contribute to existing performance measures using the Addiction Severity Index (ASI) and Global Assessment of Functioning (GAF).*

h. Attachment A provides special guidance on systems ‘work-around’ requirements and general administrative management of PR RTPs.

i. Attachment B provides guidance on clinical program requirements and considerations.

j. Attachment C provides instructions for completion of Northeast Program Evaluation Center (NEPEC) Annual Survey.

k. Attachment D describes detailed systems ‘work-around’ instructions for the Veterans Health Information Systems and Technology Architecture (VistA) setup.

5. REFERENCES

- a. VHA Directive 1000.1.
- b. VHA Manual M-1, Part I, Chapter 1.
- c. VHA Directive 99-030.
- d. Mental Health Program Guide 1103.3, dated June 3, 1999.
- e. VHA Manual M-2, Part VII, Chapter 11, "Self-Medication Program," dated August 20, 1993.
- f. VHA Manual M-1, Part I, Chapter 5, "Patient Records," dated June 8, 1995.

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6. FOLLOW-UP RESPONSIBILITY: Mental Health Strategic Health Group (116D) is responsible for the contents of this Directive. **NOTE:** *Questions may be addressed to the Office of Psychosocial Rehabilitation, Mental Health Strategic Health Group, VHA Headquarters, at (757) 722-9961, extension 3654.*

7. RESCISSIONS: VHA Directive 10-95-099 is rescinded. This VHA Directive will expire January 31, 2004.

S/ Dennis Smith for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachments

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ATTACHMENT A

**GUIDANCE ON THE ESTABLISHMENT AND ADMINISTRATIVE MANAGEMENT
OF A PR RTP**

1. STEPS FOR A VA MEDICAL CENTER TO TAKE

a. Prior to formal submission of a Psychosocial Residential Rehabilitation Treatment Program (PR RTP) proposal, it is suggested that contact be made with the Veterans Health Administration (VHA) Headquarters PR RTP Program Coordinator, Mental Health Strategic Health Group, at (757) 722-9961 x3654. This initial contact allows an opportunity for a brief consultation of the PR RTP plans to permit expeditious approval of formal proposal.

b. The following is to be submitted to the associated Veterans Integrated Services Network (VISN) Director:

(1) A proposal or plan addressing PR RTP activation, (follow format as outlined in VHA Directive 99-030, Authority for Mental Health Program Changes, dated June 30, 1999).

(2) A formal Bed Change Request in accordance with VHA Directive 1000.1.

(3) A letter to VHA Headquarters Director Information Management Service (045A4), THRU the Deputy Assistant Under Secretary for Health (10N), requesting Department of Veterans Affairs (VA) medical center assignment of "PA" suffix , to establish the PR RTP as a separate division of the associated VA medical center

2. STEPS FOR VISN TO TAKE

a. Forward VISN approved proposal to the Deputy Assistant Under Secretary for Health (10N), who will formally request comment from the Chief Consultant for Mental Health and/or other Patient Care Services Strategic Health Groups as appropriate.

b. Forward VISN approved request for PA Suffix letter to: VHA Headquarters, Director Information Management Service (045A4), THRU Deputy Assistant Under Secretary for Health (10N).

c. Upon approval of proposal by the Under Secretary for Health, process Bed Change designation in Bed Control System.

**3. STEPS FOR VA MEDICAL CENTER FISCAL, INFORMATION RESOURCE
MANAGEMENT (IRM) AND MEDICAL ADMINISTRATION SERVICE (MAS) UPON
BEDS BEING ESTABLISHED IN BED CONTROL SYSTEM:**

a. Adjust Gains & Losses (G&L) statement to designate each PR RTP as a separate line item.

b. Establish new division (activate PA suffix) in accordance with Attachment D.

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c. Acquaint Medical Records Coding Staff with the following Treating Specialty Codes, and ensure Decision Support System (DSS) staff establish appropriate DSS departments as follows:

<u>PRRTP Type</u>	<u>Treating Specialty Code</u>	<u>DSS Department</u>
PRRTP (not otherwise specified)	25	P4A1 4A 2034A1
PRRP (PTSD)	26	P4B1 4B 2034B1
SARRTP (Substance Abuse)	27	P4C1 4C 2034C1
HCMC CWT TR (Homeless)	28	P4D1 4D 2034D1
SA CWT TR (Substance Abuse)	29	P4E1 4E 2034E1
PTSD CWT TR	38	P4F1 4F 2034F1
General CWT TR	39	P4G1 4G 2034G1

4. RECURRING VA MEDICAL CENTER FISCAL, IRM, AND MAS MANUAL PROCEDURES

a. Personnel responsible for processing of G&L should submit a PRRTP workload Report (indicating PRRTP Bed Days of Care for previous month) to Fiscal Service by the 10th workday of each month.

b. Workload for PRRTPs must be manually inserted into the VHA Work Management (VWM) segment 334 to ensure it is recorded as Psychiatry workload. Additionally, Fiscal staff will ensure PRRTP workload (Bed Days of Care) is credited to Cost Distribution Report (CDR) 1700.00 series account, as appropriate for type of PRRTP established:

1711.00	PRRTP (not otherwise specified)
1712.00	PRRP (PTSD)
1713.00	SARRTP (Substance Abuse)
1714.00	HCMC CWT TR (Homeless)
1715.00	SA CWT TR (Substance Abuse)
1716.00	PTSD CWT TR (PTSD)
1717.00	General CWT TR

5. STEPS FOR SERVICE LINE CHIEFS TO DISTRIBUTE COSTS

a. The Chief of Psychiatry, Mental Health Service Line Chief and/or PRRTP Program Coordinator should be familiar with (generally two) cost categories designed to measure the treatment cost of Residential Rehabilitation services:

(1) **Residential Inpatient Costs.** Services provided to PRRTP veterans by staff assigned to and in support of the PRRTP residential unit are captured as “bed days of care” and reported to the PRRTP inpatient bed category CDR account 1700 series. **NOTE:** *These services include, but are not limited to PRRTP screening, admission, rehabilitation plan development, case reviews, therapeutic group and individual counseling associated with the residential component, meals, dietetics staff, evening staff coverage, etc.*

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(2) **Outpatient Costs.** Services provided to PR RTP veterans by staff providing services in established outpatient clinics (such as Outpatient Substance Abuse Clinics, Day Treatment programs, PCT Teams, Vocational Rehabilitation Therapy, Compensated Work Therapy, etc) are captured as “outpatient visits.” These costs are, therefore, reported to the appropriate Outpatient CDR Account in the 2000 series

***NOTE:** If all services provided to PR RTP residents are provided exclusively to them, in conjunction with the residential unit (as in a traditional hospital bed program), then all costs will be captured as Residential Inpatient Costs (1700.00 series costs).*

ATTACHMENT B**PROGRAM GUIDELINES FOR PSYCHOSOCIAL RESIDENTIAL REHABILITATION
TREATMENT PROGRAMS****1. THE CLINICAL PROGRAM**

a. Veterans in a Psychosocial Residential Rehabilitation Treatment Program (PRRTP) will have psychiatric and/or psychosocial needs which are clinically determined to benefit from a 24-hour-per-day, 7-day per week, ("24/7") structured and supportive environment as a part of the rehabilitative treatment regime. Treatment and/or therapeutic activities will be provided at least 4 hours per day, 7 days per week. Veterans should be clinically stable to be able to function outside of a medium or high intensity hospital setting and must be capable of self-preservation in case of a disaster. Veterans in a PRRTP who develop an acute psychiatric disturbance will be transferred to a medium or high intensity psychiatric program until they are stable enough to either return to the PRRTP or make other treatment arrangements. All veterans admitted to a PRRTP will have a Rehabilitation and/or Treatment Plan with specific, measurable goals to be addressed during their PRRTP episode of care. This treatment plan will encompass the full range of services planned, identifying Outpatient Treatment (OPT) clinics to be utilized, as appropriate. PRRTPs will not be used as a simple substitute for community housing or as VA lodging or Hoptel facilities.

b. The PRRTP model is designed for maximum flexibility of program design. Within this residential level of care, programming may range from relatively short-term care of limited focus (i.e., less than 30 days and targeted primarily towards diagnosis-specific education, counseling, and symptom management), to long-term, comprehensive rehabilitation (i.e., exceeding 1 year and including a full range of psychosocial services, such as life-skills training, social learning, vocational rehabilitation therapy, Compensated Work Therapy (CWT), etc.). Likewise, within various types of PRRTPs, specific, sub-populations may be targeted, (such as dually-diagnosed or geriatric populations) necessitating specialized staff and rehabilitative approaches. There may also be specific PRRTP "tracks" within targeted populations, for example: a substance abuse residential program designed for veterans with dual diagnoses, and another for veterans with a substance abuse diagnosis only, or another with a strong psychosocial rehabilitation component addressing issues of work and independent living skills. This flexibility in PRRTP program design suggests that a site may establish more than one of a specific type of PRRTP in order to most efficiently meet the rehabilitative needs of a diverse veteran population.

c. The CWT Transitional Residence (TR) programs are designed for veterans whose rehabilitative focus is based on CWT and transitioning to successful independent community living. Ongoing support is provided for diagnoses-specific conditions. CWT TRs are designed for specific populations (Homeless, Post-traumatic Stress Disorder (PTSD), etc) for purposes of tracking services and funds expended for special veteran populations. They should also be staffed with professionals possessing specialized expertise related to the populations served.

d. PRRTP Program flexibility also exists in the structure used for service delivery. There are two basic structures for Residential Rehabilitation (RR) programming.

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(1) **All Inclusive Residential Model.** The structure of the all-inclusive residential model is similar to a traditional 'inpatient' program, where staff dedicated to the PR RTP unit provide virtually all treatment and rehabilitative services, and do so exclusively for the patients in those beds. ***NOTE:** This model may provide advantages for programming which is tailored specifically for group treatment approaches. It may also be used more often for RR programs that are targeting higher acuity of illness and are, therefore, providing higher intensity of care.*

(2) **Supportive Residential Model.** This RR program structure provides a supportive residential component to augment intensive treatment provided through the Ambulatory Care System, such as Intensive Outpatient Substance Abuse program, Day Treatment program, CWT, etc) It is designed to minimize risk and maximize benefit of the ambulatory care services provided for veterans whose health and/or lifestyle necessitate a supervised, structured environment while receiving care, or those requiring comprehensive rehabilitation to learn and practice new behaviors. In addition to meeting a key agency objective (to increase outpatient services), this model may provide some of the following advantages:

- (a) The RR facility (itself) does not require staffing during the day,
- (b) Residents of the RR unit assume greater responsibility for their treatment (in that they must 'go to it', rather than have it 'come to them'),
- (c) Residents of the RR unit are exposed to other veterans in the Outpatient Treatment environments who are higher functioning (i.e., not in need of supportive 24-hour residential programming), and participate in treatment more as 'community citizens' than 'hospital patients'.
- (d) Residents of the RR unit gain familiarity and establish therapeutic relationships with Outpatient Treatment staff
- (e) Outpatients experiencing need for more comprehensive care (i.e., 24-hour residential services) may be more likely to accept such care, knowing that they will not have to establish all new therapeutic relationships by doing so.

***NOTE:** In some cases, this model has facilitated the development of previously non-existent Aftercare Services, due to increased efficiency in staff utilization (treatment staff are not assigned strictly to operate an 'all inclusive inpatient' unit, and are therefore available to provide outpatient services as well).*

2. STAFFING

a. PR RTPs require a multidisciplinary team for comprehensive assessment and rehabilitation and/or discharge planning. This team may often consist of staff from the Outpatient program(s) (such as Outpatient Substance Abuse, PTSD Clinical Team (PCT), Day Treatment, CWT, etc) where the PR RTP veterans may receive the preponderance of their clinical care. The RR team will also generally include the PR RTP Program Coordinator and staff who are assigned to facilitate the supportive nature of the residence and provide evening and/or weekend coverage on the RR unit itself. In most cases (except CWT TR programs), the evening and/or weekend

coverage will consist of paid VA staff, ranging from Nursing Assistants and/or Rehabilitation Technicians to professional Nursing staff. The type of staff required for evening and/or weekend coverage will vary, depending on:

- (1) The clinical needs of residents (use of the American Society of Addictive Medicine (ASAM) criteria to assess various domains is encouraged).
- (2) The intensity of programmatic structure (i.e., scheduled activities, individual rehabilitation plan expectations, peer support expectations, assigned residential responsibilities, etc.).
- (3) The maturity of the residential culture (the extent to which residents actually do support each other, strength of resident councils, etc.).
- (4) Accreditation requirements.

b. In some cases, such as the CWT TR's, a current or "graduate" PR RTP resident may supervise the residence in lieu of staff. These "House Managers" must have a stable, responsible, caring demeanor and have leadership qualities such as effective communication skills, ability to motivate, etc. At a minimum, House Managers, and non-professional staff are to be trained to observe resident behaviors, facilitate a healthy therapeutic environment, (i.e., encourage socialization and participation, coordinate residential activities, etc), ensure safety, and assess the need for professional medical or psychiatric intervention. Professional staff must be available on an emergency and/or call-back basis.

3. MEDICATIONS. Medications in PR RTPs are generally self-administered in accordance with VHA Manual M-2, Part VII, Chapter 11, Self-Medication Programs. These programs are structured to provide a controlled, supervised environment where veterans learn and practice self-medication skills prior to discharge. Medications are kept in a locked cabinet or locker accessible only to that veteran and designated staff personnel. In cases where a PR RTP veteran may not be ready for participation in a self-medication program, it is necessary for appropriately licensed staff to be assigned and available to administer medications to veterans in the PR RTP facility.

4. MEALS. Preparation of meals in PR RTPs may be done by the veterans themselves, or by personnel associated with a residence. When veterans assigned to the PR RTP are responsible for their meals (as is the case for all CWT TRs), sufficient staff supervision should be provided to assure patients engage in appropriate meal planning, food preparation, sanitation and safety. In some PR RTPs, especially those on medical center grounds, veterans may eat in the medical center dining room. Similar flexible arrangements will be allowed for laundry, housekeeping, and facility maintenance and repair.

5. PHYSICAL PLANT

a. A PR RTP can be established in a suitable building or residence on Department of Veterans Affairs (VA) medical center grounds; or in VA-owned, leased, or otherwise acquired community-based properties.

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- b. The facility should have a comfortable and homelike environment.
- c. There should be adequate space for group activities as well as personal space for privacy. Bedrooms should be limited to two occupants.

6. PROGRAM ADMINISTRATION. PRRTPs will generally be under the clinical supervision of the Mental Health Service Line Director, who will appoint the Coordinator for the PRRTTP. Generally the Coordinator has primary responsibility for, and for concurring in, all PRRTTP admissions and the responsibility for program policy and procedures. ***NOTE:** An Advisory Council, which could include current and/or past residents, referral sources, community members or advocacy groups, etc is encouraged as a means of initial planning and ongoing development of PRRTTP programming.*

7. ANNUAL REPORT. To facilitate the monitoring and evaluation of all PRRTPs by the Northeast Program Evaluation Center (NEPEC) and specifically of Substance Abuse Residential Rehabilitation Program (SARRTPs) by Program Evaluation Research Center (PERC), a brief annual survey report is required. ***NOTE:** NEPEC is responsible for sending an annual survey to collect the data described in Attachment C.*

8. PRRTTP MEDICAL RECORDS REQUIREMENTS. The PRRTTP record will be integrated into the Consolidated Health Record. Each period of care in a PRRTTP will be considered the equivalent of a period of care in any other VA bed (hospital, domiciliary, nursing home care unit). ***NOTE:** The medical records requirements for patients in PRRTTP beds will be equivalent to the requirements for VA Extended Care Patient Records found in VHA Manual M-1, Part I, Chapter 5, except as noted in following subparagraphs 8b, 8d, and 8e.* The PRRTTP records will include, but are not be limited to the following:

- a. **Patient Problem List.** (Optional).
- b. **Admission Note.** The Admission Note should include the veterans strengths, abilities, needs and preferences, in addition to standard admission note content.
- c. **History and Physical Exam (H&P).** (An Interval H&P, reflecting any changes since last exam, may be sufficient when deemed appropriate by professional judgment and in conformance with accrediting entities such as JCAHO.) Timeframes for completion of H&Ps should be established based on current accreditation standards. A veteran remaining on PRRTTP status for a year or longer will be given an annual examination, to include mental status.
- d. **Comprehensive Biopsychosocial Assessment.** A comprehensive assessment will be documented to include an interpretive summary that is based on the assessment data.
- e. **Rehabilitation and/or Treatment Plan.** An individualized rehabilitation treatment plan, which will include specific, measurable goals, targeted dates for completion and designated responsible individual for addressing each goal. Discharge planning will also be contained in the rehabilitation/treatment plan.

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f. **Rehabilitation Progress Notes.** The frequency of recording progress notes will be established by medical center or program policies, and will be appropriate for the veteran populations served and the program objectives.

g. **Doctor's Orders.**

h. **Informed Consent.** The provisions of Title 38 Code of Federal Regulations, Section 1734, and Title 38 United States Code 7331, and VHA policy on informed consent apply. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards also apply where not in conflict with VA regulation or policy.

i. **Discharge Summary.** The discharge summary, signed by a physician or appropriately credentialed healthcare provider will be consistent with external accreditation standards to be applied.

j. **Psychiatric Patient Records.** Unique documentation requirements for Psychiatric Patient Records will apply, as described in M-1, Part 1, Chapter 5.

ATTACHMENT C

INSTRUCTIONS FOR COMPLETING NEPEC ANNUAL PR RTP SURVEY

1. The Annual Survey of Psychosocial Residential Rehabilitation Treatment Program (PR RTP) programs should be submitted by December 1st for the most recent fiscal year ending on September 30th. Surveys are to be either mailed or faxed to:

PR RTP Evaluations
NEPEC (182)
c/o VA Connecticut Healthcare System
950 Campbell Avenue
West Haven, CT 06516
FAX: (203) 937-3433

2. The survey report should contain the following information:

- a. Name of Medical Center of Health Care System
- b. Station number,
- c. Fiscal year covered, and
- d. Name, address, and telephone number of person completing the survey.

3. Date of first admission to the PR RTP (month and year).

4. Type of PR RTP.

5. Number of operating beds.

6. Whether or not there was a change in the number of operating beds for the Fiscal Year being covered.

7. The three most frequently seen diagnostic groups in the PR RTP, ranked by order of most frequently seen.

8. The three most frequently seen special patient populations (homeless, women, elderly, etc.) in the PR RTP, ranked by order of most frequently seen.

9. The services directly provided by the PR RTP staff, rated by importance and/or the emphasis given to a selected list of services.

10. The location of the PR RTP (medical center grounds or in community).

11. Whether the PR RTP is Department of Veterans Affairs (VA)-owned or VA-leased.

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12. The number and percentage of full-time employee equivalent (FTEE) utilized to operate the PR RTP, described by position title.
13. The procedures in place for handling evening, night, and weekend coverage of the PR RTP.
14. Whether or not there is ever a time on-site in the evening, at night, or on the weekend when coverage is not provided.

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ATTACHMENT D

VISTA SETUP INSTRUCTIONS FOR PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)

(i.e., establishing a new division under the category of Domiciliary in VistA)

NOTE: The use of Domiciliary category for Veterans Health Information Systems and Technology Architecture (VistA) setup is for domiciliary-like functionality purposes only - PRRTP beds are not otherwise to be considered Domiciliary beds, but rather PRRTP (Psychiatry) beds.

1. TO ADD A NEW INSTITUTION

Select OPTION NAME: INSTITUTION FILE ENTER/EDIT DG INSTITUTION EDIT
Institution File Enter/Edit

Select INSTITUTION NAME: ALB-PRRTP (SUGGESTED NAME TO IDENTIFY PRRTP)
(e.g. first three letters of your primary division, then - PRRTP)

Are you adding 'ALB-PRRTP' as a new INSTITUTION (the 269TH)? Y (Yes)

INSTITUTION STATE: NY NEW YORK

INSTITUTION FACILITY TYPE: MC

1. MC (M&D) MEDICAL CENTER (MEDICAL AND DOMICILIARY)
2. MC (M) MEDICAL CENTER (MEDICAL LOCATION)

CHOOSE 1-2: 2

INSTITUTION STATION NUMBER: 500PA

NAME: ALB-PRRTP//

REGION:

DISTRICT:

VA TYPE CODE: MC HOSP

STATION NUMBER: 500PA//

STREET ADDR. 1: 2 3RD ST.

STREET ADDR 2:

CITY: ALBANY

STATE: NEW YORK//

ZIP: 12180

MULTI-DIVISION FACILITY: Y YES

Select INSTITUTION NAME:

2. TO ADD A NEW DIVISION (using Medical Administrative Services (MAS) Parameter Enter/Edit)

(Screen showing divisions is not being displayed at this point)

(3) Divisions: TROY (500), ALBANY (500), MOBILE CLINIC (500MO),
TEST NUMBER (500.4), CINCINNATI (539),

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ALB-PRRTP (500PA),

Select MEDICAL CENTER DIVISION NAME: ALB-PRRTP

Are you adding 'ALB-PRRTP' as

A new MEDICAL CENTER DIVISION (the 25TH)? No// Y (Yes)

MEDICAL CENTER DIVISION NUM: 541// <return>

MEDICAL CENTER DIVISION FACILITY NUMBER: 500PA

OUTPATIENT ONLY:

PRINT WRISTBANDS: Y YES

PRINT 'AA' <96' ON G&L: Y YES

PRINT 'AA' ON G&L: Y YES

NHCU/DOM/HOSP G&L: 1 SEPARATE *****

INSTITUTION FILE POINTER: ALB-PRRTP NY MC(M) 500PA

DEFAULT 1010 PRINTER:

DEFAULT DRUG PROFILE PRINTER:

DEFAULT ROUTING SLIP PRINTER:

Select MEDICAL CENTER DIVISION NAME:

NOTE: Make sure that the primary division is the one that appears as the first entry when entering the MAS Parameter Screen (If not, the last division added with display on the top of the Bed Section Report and Treating Specialty Report).

3. TO ADD A NEW WARD (Using Ward Definition Enter/Edit)

Ward Definition Entry/Edit

Select WARD LOCATION NAME: PRRTP

Are you adding 'PRRTP' as a new WARD LOCATION (the 31ST)? Y YES

WARD LOCATION HOSPITAL LOCATION FILE POINTER: PRRTP

Are you adding 'PRRTP' as a new HOSPITAL LOCATION (the 125TH)? Y (Yes)

HOSPITAL LOCATION TYPE: W WARD

HOSPITAL LOCATION TYPE EXTENSION: WARD//

WARD LOCATION G&L ORDER: 21.5 (OR WHEREVER YOU WISH TO PRINT IT)

NAME: PRRTP//

PRINT WARD ON WRISTBAND: Y YES

DIVISION: ALB-PRRTP 500PA

INSTITUTION: ALB-PRRTP NY MC(M) 500PA

ABBREVIATION: PRRTP

BEDSECTION: PRRTP

SPECIALITY: PSYCH

1 PSYCH RESID REHAB TRMT PROG

2 PSYCHIATRIC MENTALLY INFIRM

CHOOSE 1-2: 1

SERVICE: DOM DOMICILIARY

PRIMARY LOCATION: PRRTP

Select AUTHORIZED BEDS DATE: 10 1 97 OCT 01, 1997

Are you adding 'OCT 01, 1997' as a new AUTHORIZED BEDS

DATE (the 1ST for this WARD LOCATION)? Y (Yes)

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NUMBER OF AUTHORIZED BEDS: 20

SERIOUSLY ILL:

Select SYNONYM:

G&L ORDER: 21.5//

Select TOTALS: PR RTP TOTALS

Are you adding 'PR RTP TOTALS' as a new TOTALS (the 1ST for this WARD LOCATION)?

Y (Yes)

TOTALS LEVEL: 1//

PRINT IN CUMULATIVE TOTALS: Y YES

CUM TITLE: PR RTP//

Select TOTALS:

Select WARD LOCATION NAME: NCHU (OR WHATEVER YOU WANT TO PUT IT IN FRONT OF/AFTER, ETC.) NAME: NCHU//^TOTALS

Select TOTALS: GRAND TOTALS// ?

Answer with TOTALS LEVEL

Choose from:

- 1 NCHU TOTALS
- 2 DON'T DISPLAY
- 3 GRAND TOTALS

MEDICAL CENTER TOTALS	40	0	0	40
PR RTP PR RTP	3	0	1	2
PR RTP TOTALS	3	0	1	2
DOMICIL DOM	1	0	0	1
DOM TOTALS	1	0	0	1

2 NCHU NCHU	1	0	0	1
NCHU NCHU	0	0	0	0

NCHU TOTALS	1	0	0	1
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GRAND TOTALS	45	0	1	44
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4. TO PLACE WARD OUT-OF SERVICE (Using Edit Ward Out-Of-Service Dates)

Select OPTION NAME: EDIT WARD OUT-OF-SERVICE DATES DGPM

WARD OOS EDIT

Edit Ward Out-of-Service Dates

Select WARD LOCATION NAME: PR RTP

Select OUT-OF-SERVICE DATE: 10 1 97 OCT 01,1997

Are you adding 'OCT 01, 1997' as a new OUT-OF-SERVICE DATE (the 1ST for this WARD LOCATION)? Y

(Yes) OUT-OF-SERVICE DATE(S): OCT 1, 1997//

VHA DIRECTIVE 2001-010

March 1, 2001

REASON: OTHER

1 OTHER CONSTRUCTION

2 OTHER REASONS

CHOOSE 1-2: 2

COMMENT: PR RTP TRACKING

RETURN TO SERVICE DATE: 5 1 97 (MAY 01, 1997) (OR WHATEVER DATE YOU
WISH TO ACTIVATE THIS WARD) IS ENTIRE WARD OUT OF SERVICE?: Y YES
DISPLAY OOS ON G&L: YES YES

**5. TO SET UP TREATING SPECIALTY REPORT FOR THE NEW WARD
(PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM
(PR RTP))**

Select FACILITY TREATING SPECIALTY NAME: PSYCH RESID REHAB TRMT PROG
PSYCH RESID REHAB TRMT PROG

NAME: PSYCH RESID REHAB TRMT PROG//

Select EFFECTIVE DATE: OCT 1, 1997//

EFFECTIVE DATE: OCT 1, 1997//

ACTIVE?: YES//

SPECIALTY: PSYCH RESID REHAB TRMT PROG//

SERVICE: PSYCHIATRY// DOMICILIARY

Select PROVIDERS:

ABBREVIATION:

The information for the PSYCH RESID REHAB TRMT PROG treating specialty should be
entered by Medical Center Division as of midnight on Sep 30, 1997 to properly initialize the
Treating Specialty Report!

Following any new entries to or revisions of this data, the G&L MUST BE recalculated back to
Oct 01, 1997.

Select MEDICAL CENTER DIVISION NAME: ALB-PR RTP 500PA

PATIENTS REMAINING: 0

PASS PATIENTS REMAINING: 0

AA PATIENTS REMAINING: 0

UA PATIENTS REMAINING: 0

ASIH PATIENTS REMAINING: 0

TSR ORDER: 200

Select MEDICAL CENTER DIVISION NAME:

Select FACILITY TREATING SPECIALTY NAME:

6. ADMIT AND/OR TRANSFER IN-PATIENTS

7. RECALCULATE GAINS AND LOSSES (G&L) CUM TOTALS BACK TO 10/1/97

8. RUN G&L, INCLUDING BSR AND TSR

9. EXPERIMENTATION WITH NEW DIVISION AND/OR DOMICILIARY WARD FOR TRACKING PR RTP

- a. Create a new Institution file entry (ALB-PR RTP) -or whatever.
- b. Create a new Division file entry (ALB-PR RTP) -or whatever.
- c. Create a new Ward with DOMICILIARY as the SERVICE.

Place beds 00S from 10/1/97 and Return to Service whatever day you are going to start tracking. You must show Authorized Beds at this time.

- d. Set up the Treating Specialty Report for PR RTP as all zeroes for each of your current divisions.
- e. Recalculate G&L Cum Totals back to 10/1/97.
- f. Manually track any PTF records with a suffix of BU for DOM and ensure (if the facility already has a DOM), that the suffix is changed to PA.